

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05885

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

35 days

Hospital, Institution, or street address where death occurred:

Elkton Hospital

How long in hospital or institution?

30 days

3. (a) FULL NAME

Frederick Abramso

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F.

White

Married

6. (b) Name of husband or wife

James W. Abrams

7. Birth data of deceased (mo., day, yr.)

June 18 - 1861

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

78 11 20

9. Birthplace

Farmington, Cecil Co. Md

(Town, county, and state)

10. Usual occupation

none

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

James Abrams

Address

Buried

(Burial, cremation, or removal. Which?)

Date thereof

Date thereof

(month)

(day)

(year)

Cemetery or crematory

Bay View

Location

North East

Burial

Joseph A. Grant

Address

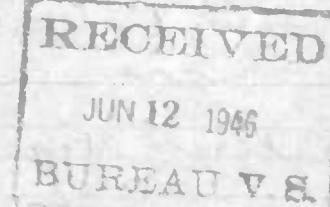
North East

Burial

J. H. Fraser

Address

J. H. Fraser



MARGIN RESERVED FOR BINDING

N. B.—**WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.** Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH 45886

1. PLACE OF DEATH

County *Cecil*Village or City *Warwick Md.*

Length of residence in city or town where death occurred

yrs. mos. ds. No. 940St. 90

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME

(a) Residence: No. *1200*

(Usual place of abode)

(b) Residence: No. *1200*

(Usual place of abode)

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UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

Gallstones	May 1, 1923

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy	JUL 5 1946	1 week ago
Run over by street car		1 week ago
Peritonitis		3 days ago

Other contributory causes of importance:

Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

Evidence for the change of
deceased birthdate is shown

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3D

Boston

05887

Reg. Dist. No. 92

FILM No. I 04 JUN 25 1946

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

City or town

Cecil

Elkton, Md

How long in above place of death?

Hospital, institution, or street address where death occurred:

Union Hospital

How long in hospital or institution?

3. (a) FULL NAME

George C. Boston

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

M.

Wh.

Married

8.(c) Name of husband or wife

Cecil Boston

7. Birth date of
deceased (mo., day, yr.)

June 18, 1894/13

(8. c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

52

11

29

hrs.

min.

9. Birthplace

Church Hill, Md

(Town, county, and state)

10. Usual occupation

None (Unemployed)

11. Industry or business

FATHER

12. Name

Sole Boston

MOTHER

13. Birthplace

Maryland

14. Maiden name

Cecil Mountain

15. Birthplace

Teresa

16. Informant

Mrs. Cecil Boston

Address

Rocky Pt. Beach, Md

17. Removal

(Burial, cremation, or removal, where)

Date thereof

(month) (day) (year)

Cemetery or crematory

Ches., Pa

Location

18. Funeral director

H. W. Lippin

Address

Elkton, Md

19. Date rec'd by registrar

June 17, 1946

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

Herrick, Pt. Beach, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

6/16 1946 at 9:40 a

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 12, 1946, to June 16, 1946, and that I last saw him alive on June 17, 1946.

Immediate cause of death

Auricular fibrillation

DURATION

5 days

Due to

Chronic myocarditis

15 years

Due to

Chronic myocarditis

15 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

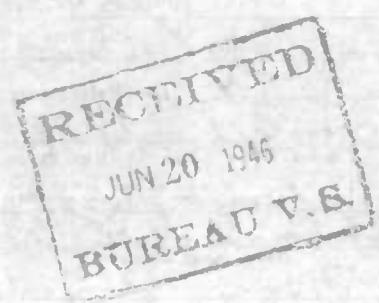
Means of injury

Injured at work?

23. SIGNATURE

H. W. Davis MD M. D. or other

Address Chesapeake, Md Date signed 6/17/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

05888

Reg. Dist. No. 42

1. PLACE OF DEATH:

County

City or town

Eccles

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Union Hosp.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

3. (a) FULL NAME

George W. Bland

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

M

White

6.(b) Name of husband or wife

Elijah Bland

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 4 1872

8. AGE:

Years

Months

Days

If less than one day

73

11

14

hrs.

min.

9. Birthplace

St. Georges Island Md.

(Town, county, and state)

10. Usual occupation

Fisherwoman

11. Industry or business

George Bland

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

Date thereof (month) (day) (year)

Chesterfield Md

Chesterfield and

Elijah Bland

Church Hill Md

H. P. Frazer

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 18 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

and that I last saw h. alive on

19

Immediate cause of death

acute Cardiac
Failure.
Due to: Chronic
Myocarditis

DURATION

Cause:

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

Medical Examiner

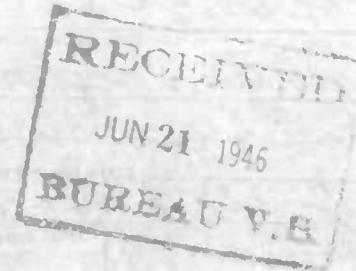
23. SIGNATURE

M. D. or other

Date signed

Address

Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-8

CERTIFICATE OF DEATH

05889

Reg. Dist. No.

96

1. PLACE OF DEATH:

CECIL

County

CITY OR TOWN: VETERANS ADMINISTRATION, PERRY POINT, MD.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

9 mo. 29 da.

Hospital, institution, or street address where death occurred:

Veterans Administration, Perry Point, Md.

How long in hospital or institution?

9 mo. 29 da.

3. (a) FULL NAME

WILLIAM H. BOGGS

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

8. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

January 13, 1894

8. AGE:

Years
52Months
5Days
12

If less than one day

hrs. — min.

9. Birthplace

Washington, D.C.

(Town, county, and state)

10. Usual occupation

Clerk

11. Industry or business

—

12. Name

William Henry Boggs

13. Birthplace

Pennsylvania

14. Maiden name

Annie Triscalla Ruth

15. Birthplace

Pennsylvania

16. Informant

Hospital Records

Address: Veterans Administration, Perry Point, Md.

17. Removal

6-27-1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Arlington National Cemetery

Location

Arlington, Va.

18. Funeral director

Fennington & Son, Havre de Grace, Md.

Address

19. Date rec'd by registrar

Date rec'd by registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State — D.C. — County —

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2730 - 10th Street, N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 25 1946, at 11:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 27 1945, to June 25 1946.

and that I last saw h. in alive on June 25 1946.

IMMEDIATE CAUSE OF DEATH

Myocardial Degeneration
with cardiac hypertrophy and

/// hypertension Due to Over 2 years DURATION

DUE TO

Other conditions Psychosis with syphilis Unknown
of Central Nervous System, Meningo-
Encephalitic type. Include pregnancy within 3 months of death

MAJOR FINDINGS OF OPERATIONS

Date of op.

AUTOPSY RESULTS

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

MEANS OF INJURY

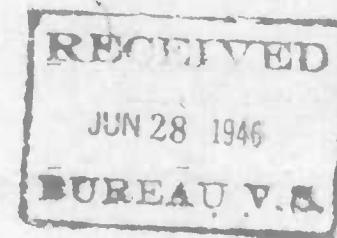
Injured at work —

33. SIGNATURE

A.E. TROLLINGER, M.D., Clinical Director

Address: Veterans Administration Date signed: 6-26-46

Perry Point, Md.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *B1a*

05890

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County **CECIL**City or town **VETERANS ADMINISTRATION, PERRY POINT, MD.**
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? **19 yrs. 30 days**

Hospital, Institution, or street address where death occurred:

Veterans Administration Hosp. Perry Point, MD.How long in hospital or institution? **Same as above**

3. (a) FULL NAME

BUSKEY, Martin J.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Single

6. (b) Name of husband or wife

6. (c) If alive, give age **—** years
7. Birth date of deceased (mo., day, yr.) **September 3, 1896**

8. AGE:

Years

Months

Days

If less than one day

49

8

30

— hrs.

— min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

12. Name **George J. Buskey**13. Birthplace **Unknown**14. Maiden name **Catherine McDonald**15. Birthplace **Unknown**16. Informant **Hospital Records**Address **Veterans Administration Hosp. Perry Point, MD.**
Removal **6-5-46** Date thereof **6-5-46** (month) (day) (year)
(Burial, cremation, or removal. Which?)Cemetery or crematory **Arlington National Cemetery**Location **Arlington, Va.***Pennington & Son*

18. Funeral director

*Pennington & Son*Address **Havre de Grace, Md.**19. *James E. Trolling* Date rec'd by registrar **19 46**Registrar **James E. Trolling**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **Maryland** County **Allegany**City or town **Cumberland** (If outside city or town limits, write RURAL and give nearest town)Street No. **537 Greenway Avenue** (If rural, give LOCATION)

2.(a) If veteran, name war

W.W. I

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH **June 2**

19 46 at 10:40 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **May 3** 19 46 to **June 2** 19 46and that I last saw him alive on **June 2** 19 46

Immediate cause of death

Chronic Nephritis with Uremia DURATION **Over 6 mo.**Due to **Arteriosclerosis, general** Over 2 yrs.

Due to

Other conditions **Dementia Precox, Hebephrenic type** OVER 19 yrs.

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results **Not performed**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE *J. E. Trolling* M.D. Clinical DirectorVETERANS ADMINISTRATION, PERRY POINT, MD. Date signed **8-4-46**

Address



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

05891

96

CERTIFICATE OF DEATH

Reg. Distr. No.

1. PLACE OF DEATH: Cecil
County.....

City or town..... Principio Furnace, Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 9 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

James B. Campbell

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Single

8. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) May 10, 1876

8. AGE: Years	Months	Days	If less than one day
70	1	2hrs.min.

9. Birthplace..... Port Deposit, Cecil Co., Md.
(Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business..... B & O Railroad

FATHER 12. Name..... John B. Campbell
13. Birthplace..... Cecil Co., Md.

MOTHER 14. Maiden name..... Anna M. Foster

15. Birthplace..... Cecil Co., Md.

16. Informant..... Elmore Campbell

Address..... Perryville, Md.

17. Burial..... Asbury
(Burial, cremation, or removal. Which?) Date thereof..... June 15, 1946
(month) (day) (year)

Cemetery or crematory..... Asbury
Location..... Port Deposit, Md. Rural

18. Funeral director..... Lee A. Patterson & Son
Address..... Perryville, Md.

19. Date rec'd by registrar..... June 15 '46 Date signed..... June 15 '46

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Cecil

City or town..... Principio Furnace, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.....
(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12th 1946 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8 1946 to June 13 1946 and that I last saw him alive on June 12 1946.

Immediate cause of death..... Coronary Thrombosis DURATION..... 30 min.

Due to..... Arterous & Coronary DURATION..... 30 min.

Due to..... General Atherosclerosis DURATION..... 10 yrs.

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

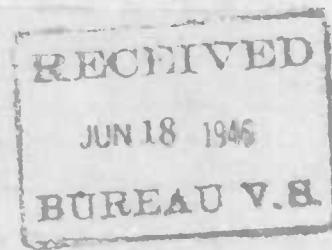
Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE J. F. Magan M. D. or other.....

Address..... Perryville Md. Date signed..... 6/10/46

Reg. No.



129-1624
Mar. 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17

05892

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

CECIL

County

BAINBRIDGE, MARYLAND.

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

U.S. NAVAL HOSPITAL

How long in hospital or institution?

3. (a) FULL NAME

COX, Baby Boy.

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1946.

8. AGE: Years Months Days If less than one day
- - - - - 1 hrs. 24 min.9. Birthplace U.S. NHOSPITAL, NTC, BAINBRIDGE, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Edwin Franklin Cox.

13. Birthplace Purdy, Missouri.

14. Maiden name Maudie Berneice Dell

15. Birthplace Exeter, Missouri.

16. Informant Edwin Franklin Cox.

Address 114 Hollingsworth Manor, Elkton, Md.

17. Cremation Date thereof
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory U.S. Naval Hospital, NTC,
Bainbridge, Maryland.

Location

18. Funeral director

Address

19. 6/13/19 Irene E. Daugherty
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

MISSOURI

County BARRY

City or town EXETER

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4, 1946. 19 at 5:10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4 June, 1946, to 4 June, 1946.

and that I last saw him alive on 4 June, 1946.

18.

Immediate cause of death

Prematurity -6 months gestation.

DURATION

1 hour

Induced labor because of pyelitis
of pregnancy.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Graham R. Johnston, Comdr. (MC), USN
M. D. or other

Address: USN TRA CEN, BAINBRIDGE, MD Date signed: 4 June, 1946

RECEIVED

JUN 15 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *BC*

05893

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

CECIL

County.....

VETERANS ADMINISTRATION, PERRY POINT, MD

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs. 4 mo. 6 d.

Hospital, institution, or street address where death occurred:

Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

3. (a) FULL NAME

DEAN, Earl E.

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 1-13-1892

6. (c) If alive, give age _____ years

8. AGE:

Years
54Months
5Days
1

If less than one day

..... hrs. min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

None

11. Industry or business

-

12. Name.....

Unknown

13. Birthplace.....

Unknown

14. Maiden name.....

Unknown

15. Birthplace.....

Unknown

16. Informant.....

Hospital Records,

Perry Point, Md.

Address

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof..... June 14, 1946

(month) (day) (year)

Odd Fellows

Cemetery or crematory

Location.....

Seaford, Delaware

18. Funeral director.....

Burroughs & Son

Address

House de Grasse and

June 14, 1946 - June E. DeAngelo

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Delaware

County..... Sussex

City or town.....

- Seaford

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

None

(If rural, give LOCATION)

2.(a) If veteran, name war.....

WW I

3. (b) Social Security Number

-

MEDICAL CERTIFICATION

2D. DATE OF DEATH

June 14

19 46, at 12:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 8

19 46, to June 14 19 46

and that I last saw him alive on June 14 19 46

Immediate cause of death

Tuberculosis, Pulmonary, chronic, far advanced with tuberculous complications

DURATION

20 years

Due to

Other conditions..... Dementia Precox, Simple

Type

(Include pregnancy within 8 months of death)

Over 20 years

Major findings or operations

Date of op.

Autopsy results..... Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

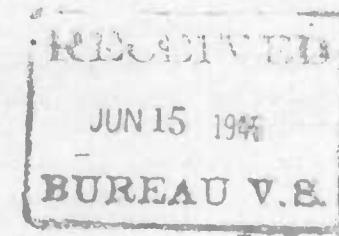
Injured at work

23. SIGNATURE

A. E. TROLLINGER, M.D. Clinical Director
Veterans Administration Hospital, Perry Point, Md.

Address

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County.....

City or town.....

Eccles
Eckton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

0

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

0

3. (a) FULL NAME

Harry S Dean Jr.

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M. White Single

6. (b) Name of husband or wife.....

7. Birth date of
deceased (mo., day, yr.)

6. (c) If alive, give age.....

years

June 13 1921

8. AGE:

Years

Months

Days

If less than one day

24 11 29

hrs. min.

9. Birthplace.....

Lancaster Pa

(Town, county, and state)

10. Usual occupation.....

Bus Driver

11. Industry or business

FATHER

12. Name.....

Harry S Dean Sr

MOTHER

13. Birthplace.....

Lancaster Pa

14. Maiden name.....

Ida C Tompkins

15. Birthplace.....

Lancaster Pa

16. Informant.....

Fred F Groff

Address

Lancaster Pa

17. Removal.....

Date thereof.....

June 15 1946

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Cedar Lawn

Location.....

Lancaster Pa

18. Funeral director.....

H C Wippin

Address.....

Eckton Maryland

19. Date rec'd by registrar.....

June 12 1946

(Date rec'd by registrar)

H Fraser
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Pa. County.....

City or town.....

Lancaster (If outside city or town limits, write RURAL and give nearest town)

Street No. 137 E. clay st.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 11 1946 at 11:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to.....

19.....

and that I last saw h..... alive on.....

Immediate cause of death.....

Compound
fracture of
skull.

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County) (State)

Injured at home, farm, industry, public place (where?).....

Highway

Means of injury.....

Automobile

Injured at work?.....

Medical Examiner

23. SIGNATURE.....

Pleasants

M. D. or other

Address.....

Pleasant

Date signed.....

6/12/46

RECEIVED

JUN 14 1946

BUREAU V 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

05895

95

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... *Cecil*City or town..... *Port Deposit Rural*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *5 years*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Joseph Christie Devonshire

3. (b) Social Security No.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*Male**white**married*6. (b) Name of husband or wife *Linnie Lee Devonshire*

7. Birth date of deceased (mo., day, yr.)

*Dec-10, 1885*8. (c) If alive, give age *44* years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace *Port Deposit Cecil Co. Md.*

(Town, county, and state)

10. Usual occupation *Husman*

11. Industry or business

12. Name *Thomas Devonshire*13. Birthplace *Md.*14. Maiden name *Clara Grounds*15. Birthplace *Md.*16. Informant *mrs Christie Devonshire*Address *Port Deposit Md.*Date thereof *June 11, 1946*
(month) (day) (year)Cemetery or crematory *Pine Banks*Location *near Rising Sun Md.*18. Funeral director *J. E. Tyson*Address *Rising Sun Md.**June 18, 1946, at Washington
Cemetery, 6001 1/2 North Washington
Street, Baltimore, Md.*

MEDICAL CERTIFICATION

20. DATE OF DEATH *June 7, 1946*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased

..... to

and that I last saw h..... alive on

Immediate cause of death *acute bronchitis**fluorrheas*

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged at

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Medical Examiner *W. E. Barker, M.D., Cecil County*23. SIGNATURE *W. E. Barker, M.D.*

M. D. or

Address *W. E. Barker, M.D., Cecil County*

Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MS A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05896

CERTIFICATE OF DEATH

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

CECIL

County

Veterans Administration, Perry Point, Md.

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

10 days

Residential institution, or street address where death occurred:

Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above.

3. (a) FULL NAME

FORD, Paul

4. Sex

Male

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Fannie Ford

6. (c) If alive, give age Unknown years

7. Birth date of deceased (mo., day, yr.)

March 12, 1896

8. AGE:

Years
50Months
2Days
29If less than one day
- hrs. - min.

9. Birthplace

Unknown

(Town, county, and state)

10. Usual occupation

Unknown

11. Industry or business

-

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Hospital Records

Address Veterans Administration, Perry Point, Md.

17. Removal

Date thereof June 11, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Warrenton, Va. Cemetery

Location

Warrenton, Va.

18. Funeral director

Pennington & Son

Address

Pennington & Son, Havre de Grace,
Maryland.June 11, 1946
(Date rec'd by registrar)June 11, 1946
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Va.

County Fauquier

City or town Warrenton

(If outside city or town limits, write RURAL and give nearest town)

Street No. E. Main Street

(If rural, give LOCATION)

2.(a) If veteran, name war

WW I

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 10

1946, 11:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 31, 1946, to June 10, 1946.

and that I last saw him alive on June 10, 1946.

Immediate cause of death

Heart Disease, Hypertension and arteriosclerotic, myocardial enlargement

Due to Over 1 yr.

Due to

Other conditions Cerebral syphilis, Meningo-vascular type
(Include pregnancy within 3 months of death) Unknown

Major findings of operations

Date of op.

Autopsy results

Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. E. TROLLINGER, M.D., Clinical Director
Acting for the Manager, Veterans Administra-
tion Hospital, Perry Point, Md. Date signed June 11, 1946

RECEIVED

JUN 13 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10

05897

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

12 hours

Hospital, Institution, or street address where death occurred:

Union Hosp.

How long in hospital or institution?.....

12 hours

3. (a) FULL NAME

Raymond Leterwood

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

col

Married

6. (b) Name of husband or wife.....

Ada Leterwood

7. Birth date of deceased (mo., day, yr.)

Sept 7 1902

6. (c) If alive, give age..... years

40

8. AGE:

Years

Months

Days

If less than one day

43

9

18

hrs.

min.

9. Birthplace.....

(Town, county, and state)

Ebensville Md.

Laborer.

10. Usual occupation.....

11. Industry or business

FATHER

12. Name.....

Benjamin Leterwood

13. Birthplace

28 Negro mulatto

14. Maiden name.....

city chitlery styles.

MOTHER

15. Birthplace

Ebensville Md.

16. Informant.....

Ada Leterwood

Address

Cemetery Road.

17. Burial

(Burial, cremation, or removal) Which?

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Celtis Colored Cemetery

Location.....

Celtis Md.

18. Funeral director.....

Edward F. Foy

Address

Wilmington Md.

19. June 20.....

1946.....

(Date rec'd by registrar)

F. F. Frazer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

220-07-7736

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

June 25 1946 at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19....., to.....

19.....

and that I last saw h..... alive on.....

19.....

Immediate cause of death.....

Pneumonia

DURATION

Due to.....

Pneumonia

Due to.....

Pneumonia

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Pneumonia

DATE OF op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

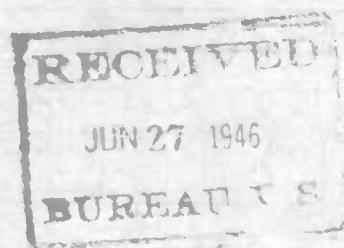
Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

Medical Examiner for Cecil County

23. SIGNATURE..... M. D. or other

Address..... Date signed.....



PLEASE WRITE PLAINLY, WITH UNRAZING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

169

05898

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County CECIL

City or town PERRY POINT, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, Institution, or street address where death occurred:

Veterans Administration Hospital, Perry Point,

How long in hospital or institution?

Same as above

Md.

3. (a) FULL NAME

GRIFFEE, John F.

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Married

6.(b) Name of husband or wife

Leda M. Griffee

7. Birth date of deceased (mo., day, yr.)

September 19, 1905

6.(c) If alive, give age 39 years

8. AGE:

Years

Months

Days

If less than one day

40 9

3

- hrs.

- min.

9. Birthplace

(Town, county, and state)

Elwood, Indiana

10. Usual occupation

Newspaper Reporter

11. Industry or business

Newspapers

MOTHER FATHER

Delmar Griffee

12. Name

Indiana

13. Birthplace

Eva Ogden

14. Maiden name

West Virginia

15. Birthplace

16. Informant

Records - Vets. Adm. Hospital

Address

Perry Point, Md.

17. Removal

Date thereof June 25, 1946

(Burial, cremation, or removal. Where)

Arlington National

Cemetery or crematory

Ft. Myer, Virginia

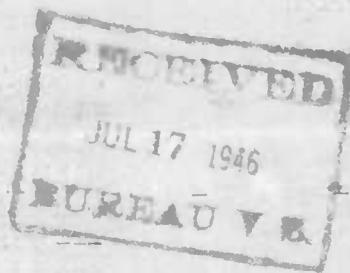
Location

PENNINGTON & SON, Havre de Grace, Md.

18. Funeral director

Pennington & Son

Address



RECEIVED
JUL 17 1946
BUREAU V R

JUL 11 1946 10:30 AM

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *2d*

05899

CERTIFICATE OF DEATH

Reg. Dist. No. *91*

1. PLACE OF DEATH:

County.....

City or town.....

Baltimore, Maryland, Chesapeake City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... *30 days*

Hospital, institution, or street address where death occurred:

Chesapeake City, Md. P.O.

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F. Col. Widowed

6. (b) Name of husband or wife.....

Charles Griffen

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Unknown

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

Chestertown, Md.

(Town, county, and state)

10. Usual occupation.....

at home

11. Industry or business

FATHER

12. Name..... *Thomas Henson*

MOTHER

13. Birthplace..... *Green Ann Co. Greenbriar, Md.*

MOTHER

14. Maiden name..... *Lizzie Coffin*

MOTHER

15. Birthplace..... *Dover, Del.*

MOTHER

16. Informant..... *William Henson*

MOTHER

Address..... *Chesapeake City P.O. Md.*

MOTHER

17. Burial..... *Burial* Date thereof..... *June 12 1946*

(Burial, cremation, or removal, Which?)

(month) (day) (year)

MOTHER

Cemetery or crematory..... *Manor Cemetery*

MOTHER

Location..... *Chesapeake City, P.O. Md.*

MOTHER

18. Funeral director..... *H. W. Tippin*

MOTHER

Address..... *Elkton, Md.*

MOTHER

19. Date..... *June 11 1946* (Date record by registrar)

MOTHER

20. Date..... *June 12 1946* (Date record by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md. County.....

City or town.....

Rural near Chesapeake City

Street No.....

Md. (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... *June 4 - 1946* a.m. *1946*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1 - 1946 to *June 4 1946*and that I last saw h...er alive on *June 4 1946*

Immediate cause of death.....

cardiac insufficiency

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

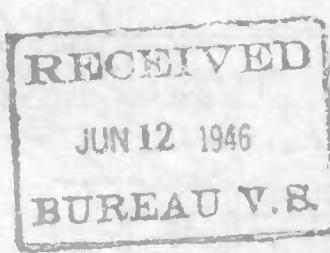
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE.....

*Judith H. Henson, Mrs. J. H. Henson*M. D. or other *M. D.* Date signed *June 5 1946*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3

CERTIFICATE OF DEATH

Reg. Dist. No. 91

1. PLACE OF DEATH: Cecil

County

City or town Chesapeake City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Biddle St

How long in hospital or institution?

3. (a) FULL NAME

Katherine Florence Farmer

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F. wh Widowed6. (b) Name of husband or wife: Nelson Farmer

7. Birth date of deceased (mo., day, yr.)

Oct 20, 1858

(c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Chesapeake Delware

(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

FATHER

12. Name Edward Downey

MOTHER

13. Birthplace Delware

Maiden name

14. Melvina Titter

15. Birthplace

Delware

16. Informant

Mrs Florence Biggs

Address

Chesapeake City, Md

17. Burial

(Burial, cremation, or removal, which?) Burial Date thereof June 11 142

(month) (day) (year)

Cemetery or crematory

Bethel

Location

New Chesapeake City, Md

18. Funeral director

H. W. Pippin

Address

Elkton, Md

19.

June 11th 1944

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Cecil

City or town

Chesapeake City

Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Biddle St.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 7 194421. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1934 to June 7 1944and that I last saw her alive on June 7 1944

Immediate cause of death

Auto myocarditis failureDue to Chronic myocarditisDue to old age

Other conditions

Gangren of toe (right foot)

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

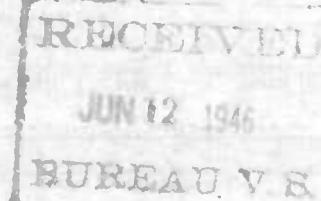
H. W. Downey M.D.

M. D. or other

Address

Chesapeake City

Date signed



PLEASE WRITE PLAINLY, WITH ~~PRINTING~~ INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 810

05903

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: CECIL

City or town: VETERANS ADMINISTRATION, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years 7 mo. 13 days

Hospital, Institution, or street address where death occurred:

Veterans Administration Hospital, Perry Point

How long in hospital or institution? Same as above Md

3. (a) FULL NAME

GEORGE N. HOLMLIN

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Single

6. (b) Name of husband or wife: —

7. Birth date of deceased (mo., day, yr.) July 23, 1900

8. AGE: Years	Months	Days	If less than one day
45	11	6	hrs. — min.

9. Birthplace: Jonkiping, Sweden
(Town, county, and state)

10. Usual occupation: Mechanic

11. Industry or business: —

FATHER
12. Name: John Holmlin
13. Birthplace: Sweden

MOTHER
14. Maiden name: Anna Adquist Holmlin
15. Birthplace: Sweden

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal
(Burial, cremation, or removal. Which?) Date thereof: 7-2-1946
(month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Maryland

18. Funeral director: PENNINGTON & SON, Havre de Grace,
Address: Maryland

19. July 2 1946 Dr. E. H. Lloyd
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED: No home address

(For newborn infants give residence of mother)

Admitted from St. Elizabeth's Hospital

State: County: Washington, D.C.

City or town: (If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2. (a) If veteran, name war: WW I ★

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 29 1946, at 10:50 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 16 1938, to June 29 1946.

and that I first saw him alive on June 29 1946.

Immediate cause of death: Chorea, Post Encephalitis

DURATION: Over 8 yrs

Due to: —

Due to: —

Other conditions: Psychosis with Chorea

post encephalitis Over 8 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op: —

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

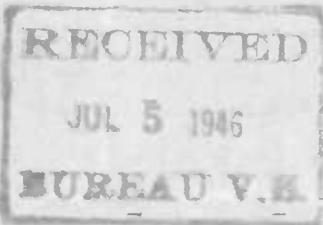
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: — Injured at work? —

23. SIGNATURE

E. E. TROLLINGER, M.D., Clinical Director or other
Veterans Administration, Perry Point, Maryland Date signed July 1, 1946



RECEIVED

A faint, handwritten signature or stamp that appears to read "RECEIVED". It is located at the bottom left of the page, below the main stamp.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13th

CERTIFICATE OF DEATH

05902

Reg. Dist. No. 42

1. PLACE OF DEATH:

County

Cecil.

City or town

Rural near Elton, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Ralph Holmes

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M.

Wh.

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

March 25, 1921

years

6. (c) If alive, give age

8. AGE:

Years
25Months
3Days
1If less than one day
hrs. min.

9. Birthplace

Elton, Md.

(Town, county, and state)

10. Usual occupation

Postalite Co.

11. Industry or business

MOTHER

FATHER

Gordon Holmes

13. Birthplace

Elton R.D. 1, Md.

14. Maiden name

Catharine Rothwell

15. Birthplace

Cherry Hill, Md.

16. Informant

Ernest Holmes

Address

Elton R.D. 1, Md.

17. Burial

Date thereof

June 10/46

(Burial, cremation, or removal, which?)

(month) (day) (year)

Cemetery or crematory

Elton.

Location

Elton, Md.

18. Funeral director

H.W. Pippin

Address

Elton, Md.

19. (Date rec'd by registrar)

June 10 1946

F.P. Fraser

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Cecil

City or town

Rural near Elton, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Elton R.D. 1

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

216-05-6842

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 7 - 1946 at 6.00

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1 - 1946 to June 7 - 1946

and that I last saw h. in alive on June 6 - 1946

Immediate cause of death

Pulmonary Tho.

DURATION

2 1/2 hr

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

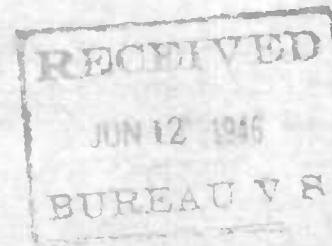
23. SIGNATURE

Jas. J. Pippin, M.D.

M. D. or other

Elton, Md. Date signed June 7/46

Address.....



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 308

05904

CERTIFICATE OF DEATH

Reg. Dist. No. 98

1. PLACE OF DEATH:

County... CecilCity or town... Perry Point, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs. 3 da. 10 mos.

Hospital, institution, or street address where death occurred:

Veterans Administration HospitalHow long in hospital or institution? 8 yrs. 3 da. 10 mos.

3. (a) FULL NAME

HULTS, Lyle

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of ~~husband~~ of wife... Mrs. Ruth Hults

6. (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.) about 18978. AGE: Years 48 Months 8 Days 22 If less than one day hrs. min.9. Birthplace... Terra Haute, Ind.

(Town, county, and state)

10. Usual occupation... Salesman11. Industry or business Automobile Agencies12. Name... Silas N. Hults - deceased13. Birthplace Ohio14. Maiden name... Ida M. Lawrence15. Birthplace Indiana16. Informant... Records - Veterans Administration

Address

Perry Point, Md.17. Removal Removal Date thereof June 24, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington National CemeteryLocation Fort Myer, Va.18. Funeral director S. H. HINES
Address 2901 14th St., N.W., Washington, D.C.19. June 28, 1946 June 28, 1946 June 28, 1946
(Date rec'd by registrar) June 28, 1946 June 28, 1946 June 28, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... D.C.

County

City or town... Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1604 Madison St., N.W.(If rural, give LOCATION) World War I

2.(a) If veteran, name war...

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2319. 46 at 8:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 20, 1937 to June 23, 1946and that I last saw him alive on June 23, 1946

Immediate cause of death...

MYOCARDIAL DEGENERATION

DURATION

unknown

Due to...

General Paralysis of the Insane over 9 yrs.

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings or operations...

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

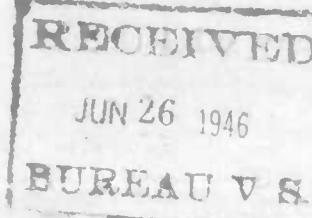
Means of injury

Injured at work?

23. SIGNATURE

A. E. TROLLINGER, M.D. CLINICAL DIRECTOR
Vets. Adm. Hosp., Perry Point, Md. Date signed 6-24-46

Address



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92

CERTIFICATE OF DEATH

05905

Reg. Dist. No. 96

1. PLACE OF DEATH:

Cecil

City or town Perry Point, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 yrs. 9 mos. 21 days

Hospital, Institution, or street address where death occurred:

Veterans Administration Hospital

How long in hospital or institution? 16 yrs. 9 mos. 21 days

3. (a) FULL NAME

LAMBERT, George F.

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Divorced

6. (b) Name of husband or wife Flora Lambert

6. (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) December 3, 1896

8. AGE: Years 49 Months 2 Days 11 If less than one day hrs. min.

9. Birthplace Canonsburg, Pa. (Town, county, and state)

10. Usual occupation Shop Worker - Machinist

11. Industry or business Tinplate Company

12. Name Robert Lambert

13. Birthplace Unknown

14. Maiden name Annie Nicholson

15. Birthplace Unknown

16. Informant Records - Vets. Adm. Hospital

Address Perry Point, Md.

17. Removal Date thereof 6-17-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oak Springs

Location Canonsburg, Pa.

18. Funeral director Pennington & Son, Hatre de Grace,
Address Md.

19. June 17 1946 (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pennsylvania County Washington

City or town Canonsburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war World War I ★

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1946 at 9:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 23 1929 to June 14 1946.

and that I last saw h. im. alive on June 14 1946.

Immediate cause of death CORONARY OCCLUSION DURATION 24 hrs.

Due to Coronary Arteriosclerosis

Due to Chronic Myocarditis over 1 yr.

Other conditions.

Dementia Praecox, Hebephrenic type 17 yrs.
(Include pregnancy within 3 months of death)

Major findings of operations.

Date of op. —

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. — Date of. —

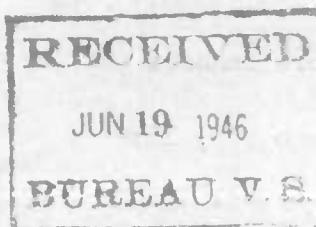
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE

A. E. TROLLINGER, M.D. CLINICAL DIRECTOR
Address V.A.H., Perry Point, Md. Date signed 6-15-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 402

CERTIFICATE OF DEATH

Reg. Dist. No. 94

0590794

1. PLACE OF DEATH:

County..... Cecil
 City or town..... North East
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs 10 mos
 Hospital, institution, or street address where death occurred: Logan

How long in hospital or institution? 1

3. (a) FULL NAME

H. Harry Logan

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Annie Harris Logan

7. Birth date of deceased (mo., day, yr.) Nov. 18 1862 8. (c) If alive, give age 83 years

8. AGE: Years 83 Months 7 Days 7 If less than one day hrs. 0 min. 0

9. Birthplace North East Cecil Co. Md.
 (Town, county, and state)

10. Usual occupation Safton

11. Industry or business Church sexton

12. Name Robert Taylor Logan

13. Birthplace Unknown

14. Maiden name Caroline Taylor

15. Birthplace Penna

16. Informant Miss Frances Logan

Address North East, Md.

17. Burial Burial Date thereof June 14 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Methodist cemetery

Location North East, Md.

18. Funeral director Joseph R. Grant

Address North East, Md.

19. Date rec'd by registrar June 14 1946 Date signed June 14 1946

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil
 City or town North East

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11, 1946 to June 11, 194621. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943 to June 11, 1946and that I last saw him alive on June 16, 1946

Immediate cause of death

Carcinome Of Rectum

DURATION

3 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

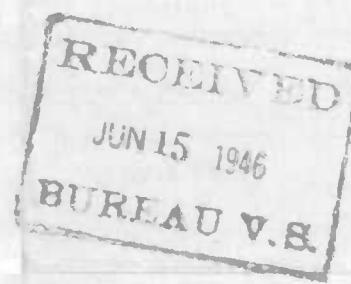
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address North East, Md. Date signed June 14 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:
County.....
City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....
15 days

Hospital, institution, or street address where death occurred:

Union Hospital

How long in hospital or institution?.....
15 days

3. (a) FULL NAME

Barbara Jean McDowell

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....
May 22 1946

8. AGE: Years Months Days If less than one day,.....
1 15

9. Birthplace.....
Elkton, Cecil Co. Md
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name.....
Harvey Francis McDowell

MOTHER 13. Birthplace.....
Maryland

14. Maiden name.....
Margie Coulson

15. Birthplace.....
Md

16. Informant.....
Harvey Francis McDowell

Address.....
North East R of Md

Burial.....
(Burial, cremation, or removal, Which?) Date thereof.....
Catholic June 7 1946

Cemetery or crematory.....
Location.....
Elkton Md

18. Funeral director.....
Joseph R. Frank

Address.....
North East Rd

19. Date rec'd by registrar.....
June 7 1946

(Date rec'd by registrar) 3 K Fraser
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Md County.....
Cecil

City or town.....
Elkton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....
June 6 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
5-22-46 19..... to 6-5 19.....

and that I last saw her alive on 6-5 1946

Immediate cause of death.....

Premature birth
7 1/2 months gestation

Due to.....

DURATION

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

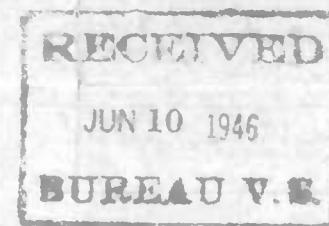
Means of injury..... Injured at work?

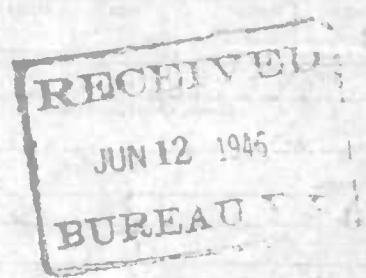
23. SIGNATURE..... M. D. or other

Date signed 6-6-46

STANISLOV TRUMENOVIC STATE MINISTER

AMBASSADOR EXTRAORDINARY





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

05910

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M.

White

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

Mar 15 1945

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

8

7

5

9. Birthplace

Elkton

Md.

(Town, county, and state)

10. Usual occupation

Deals

.

11. Industry or business

FATHER

12. Name

William

Alfred

Riggs Jr.

13. Birthplace

Elkton

Md.

14. Maiden name

Lydia

Cresswell

15. Birthplace

Elkton

Md.

16. Informant

William

A. Riggs

Address

Elkton

Md.

17. Burial

Burial

Date thereof

June 23/46

(month) (day) (year)

Cemetery or crematory

Cherry Hill

.

Location

Cherry Hill

Md.

18. Funeral director

H. A. Pippin

.

Address

Elkton

Md.

19. Date rec'd by registrar

June 22

1946

Date

J. R. Frazer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Cecil

City or town

Elkton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to

19.

and that I last saw h. alive on

Immediate cause of death

Bronchial
Pneumonia

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

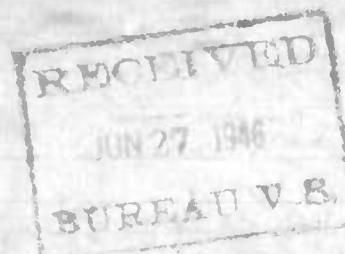
23. SIGNATURE

Dale Dodson M.D. for Cecil County

M. D. or other

Address: Rising Sun Md. Date signed: 6/20/46

GA



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1248

CERTIFICATE OF DEATH

115911
Reg. Dist. No.

1. PLACE OF DEATH:

County..... CecilCity or town..... Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Union

How long in hospital or institution?

2 weeks 6 days

3. (a) FULL NAME

Oscar J Saxon

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Laura Mary Saxon

7. Birth date of deceased (mo., day, yr.)

June 30 1893

6. (c) If alive, give age

34 years

8. AGE: Years Months Days If less than one day

53 11 17 hrs. min.

9. Birthplace

Andrea Cecil Co. Md.
(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

Albanus Saxon

12. Name

Albanus Saxon

13. Birthplace

Md

14. Maiden name

Mary Sleath

15. Birthplace

Md

16. Informant

Laura Mary Saxon

Address

Elkton Rd 2 Md

17. Burial

Date thereof

June 19 1946

(Burial, cremation, or removal, Which?)

(month) (day) (year)

RECEIVED
JUN 21 1946
BUREAU F.B.I.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

05912
95

Reg. Dist. No.

1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Married

7. Birth date of deceased (mo., day, yr.)

March 4 1882

8. (c) If alive, give age ... 52 years

8. AGE:

Years

Months

Days

If less than one day

64

3

hrs.

min.

9. Birthplace

Towt Run Pa.

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Jewell Slivres

12. Name

Jewell Slivres

MOTHER FATHER

13. Birthplace

Towanda Pa.

MOTHER FATHER

14. Maiden name

Ellen Basiley

15. Birthplace

Towson

16. Informant

Ema E. Slivres

Address

Liberty Grove Pa.

17. Burial

(Burial, cremation, or removal, Where?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Baptist Cem

Location

Conglomo Md.

E. E. Tyron

18. Funeral director

Rising Sun Md.

Address

Rising Sun Md.

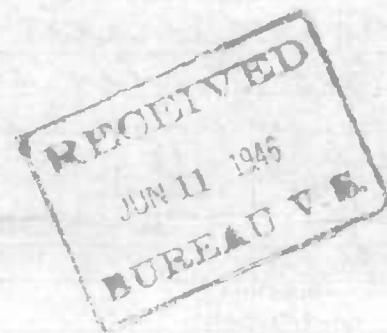
19. (Date record by registrar)

June 8 1946

19.

Date record by registrar

19.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05913

Reg. Dist. No. 96

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

Cecil

County

Veterans Adm. Hospital, Perry Point, Md.

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

7 days

Hospital, institution, or street address where death occurred:

Veterans Administration Hosp., Perry Point, Md.

How long in hospital or institution?

Same as above

3. (a) FULL NAME

SUNDAY, George W.

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mary D. Sunday

6. (c) If alive, give age Unknown years

7. Birth date of deceased (mo., day, yr.)

December 29, 1878

8. AGE:

Years
67Months
5Days
19If less than one day
- hrs. - min.

9. Birthplace

Bellefonte, Pa.

(Town, county, and state)

10. Usual occupation

Unknown

11. Industry or business

-

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Hospital Records

Address Veterans Administration, Perry Point, Md.

17. Removal

6-18-46

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Union Cemetery

Location

Bellefonte, Pa.

18. Funeral director

Pennington & Son, Havre de Grace,

Address

Md.

19. June 18, 1946

(Date rec'd by registrar)

Irene E. Daugherty

Registrar

23. SIGNATURE

TROLLINGER, M.D., Clinical Director

Acting for the Manager

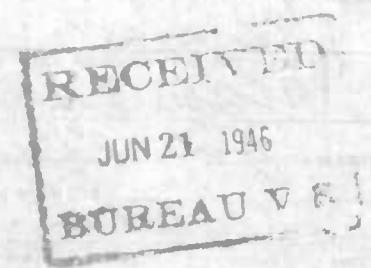
Veterans Administration

Date signed 6-18-46

RECEIVED

JUN 20 1946

BUREAU F B I



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9

CERTIFICATE OF DEATH

05914
Reg. Dist. No. 961. PLACE OF DEATH:
County.....Cecil.....City or town.....Veterans Administration Hosp. Perry Point
(If outside city or town limits, write RURAL and give nearest town)

Md.

How long in above place of death?.....22 yrs. 23 days

Hospital, institution, or street address where death occurred:

Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

3. (a) FULL NAME

WELLS, John N.

4. Sex.....Male.....5. Color or race.....White.....6. (a) Single, married, widowed, or divorced.....Widower.....

6. (b) Name of husband or wife.....Unknown.....

7. Birth date of deceased (mo., day, yr.).....November 14, 1887.....

8. AGE: Years.....58.....Months.....6.....Days.....19.....If less than one day.....-.....hrs.....-.....min.....

9. Birthplace.....Washington, D.C.
(Town, county, and state)

10. Usual occupation.....Painter.....

11. Industry or business.....-

MOTHER FATHER
12. Name.....Unknown.....

13. Birthplace.....Unknown.....

14. Maiden name.....Unknown.....

15. Birthplace.....Unknown.....

16. Inform Hospital Records, Veterans Administration Hospital, Perry Point, Md.

Address.....Perry Point, Md.
Date thereof.....6-4-46
(Burial, cremation, or removal. Which?)

Cemetery or crematory.....Mt. Olivet Cemetery.....

Location.....Washington, D.C.

18. Funeral director.....William H. Murphy, Esq.
Address.....7557 Wisconsin Avenue, Bethesda, Md.19. June 3 1946 Death certificate
(Date rec'd by registrar)2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State.....D.C.....County.....

City or town.....Washington
(If outside city or town limits, write RURAL and give nearest town)Street No.....4847 Park Ave., Washington, D.C.
(If rural, give LOCATION)

2.(a) If veteran, name war.....WW I.....

3. (b) Social Security Number.....

MEDICAL CERTIFICATION

JUNE

20. DATE OF DEATH.....May 3.....1946.....at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10, 1946, to June 3, 1946.

and that I last saw him alive on June 3, 1946.

Immediate cause of death.....Coronary Occlusion.....

DURATION.....Approx. 3 hrs.

Due to.....Disease of the Coronary Artery, arteriosclerosis.....

Unknown.....

Due to.....

Other conditions.....Dementia Precox, Paranoid type.....

V.....Over 22 yrs.
(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....Not performed.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town).....(County).....(State).....

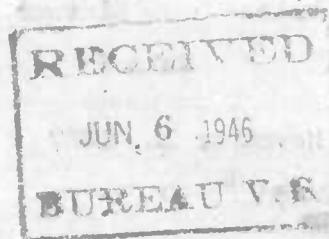
Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work.....

23. SIGNATURE.....

A.E. TROLLINGER, M.D. Clinical Director
M.D. or otherAddress.....Veterans Administration.....Date signed.....June 4, 1946
Perry Point, Md.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 189

CERTIFICATE OF DEATH

Reg. Dist. No. 1159974

1. PLACE OF DEATH:

County

City or town

South East Rural.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M White Single

6. (b) Name of husband or wife

7. Birth date of deceased (m.e., day, yr.)

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Removal (Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Md. Cecil
South East Rural.

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 10 1946, a.m. 11:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.

, fe

19.

and that I last saw h. alive on

19.

Immediate cause of death

Drowned.

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 6-10-46
Where did injury occur? South East Cecil Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Fell in River Injured at work? No (Medical Examiner)

23. SIGNATURE

M. D. or other

Address Bladensburg Md. Date signed 6-11-46

